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On the Sociology and Social Organization of Stigma: Some Ethnomethodological Insights

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Abstract. Although "stigma" has evolved as a remarkably widespread concept in the social sciences, the concept has almost never, as such, been subject to inquiry or overt definition, with the notable exception of Goffman's insights concerning it. In this paper I topicalize stigma in its use by social scientists and consider its utility in concrete social situations as organized by interactants. My central claim is that "stigma" has become under-defined and over-used. In making these points I examine two interrelated but distinct issues. The first of these concerns the "meaning" of stigma as exposed (almost always implicitly) in literature in sociology and other behavioural sciences. My goal here is to ascertain the discursive construction of stigma as a phenomenon that is amenable to study and especially to *use* as an interpretive and explanatory resource in social and behavioural sciences. As a second topic I consider by way of empirical demonstration the lived experience of persons who have what might be termed a "stigmatizing" condition – specifically, survivors of stroke – to address the paltriness of "stigma" as an omniscient summary of their circumstances.

Introduction

Erving Goffman (1968) defined "stigma" as an expectation of a discrediting judgment of oneself by others in a particular context. It has evolved as one of the most useful (or, at least, the most used) concepts in sociology, psychiatry, social psychology, medical behavioural science, and for practitioners in public health, counselling, social work and criminal justice settings. However, stigma *per se* has almost never, excepting the work of certain analysts, such as Goffman (1968), Page (1984) and Schur (1980), been subject to inquiry or overt definition. I seek in this paper to topicalize stigma in its use by social scientists and to consider its possible utility in concrete social situations as organized by real actors.

My central claim in this project is that stigma has become an underdefined and overused concept. In making these points I examine two interrelated but distinct issues. The first of these concerns the meaning of stigma as exposed (almost always implicitly) in literature in sociology and other behavioural sciences. This first topic addresses how stigma exists as a focus in the use of language and "reality construction" in which practitioners in the human sciences engage when they produce written work. My goal here is not to

ascertain the existence or non-existence of stigma, but rather, to uncover the construction of stigma as a phenomenon that is amenable to study and especially that is amenable to *use* as an interpretive and explanatory resource in social and behavioural science.

I will as a second topic consider, as a concrete, if brief, empirical demonstration, the lived experience of persons who have what might be termed a "stigmatizing" condition – specifically survivors of stroke – to address the problem of stigma as a social scientific gloss (Jefferson, 1985), or a shorthand summary, of their circumstances. To discuss this problem I will consider whether and how interactants in this context actually reference, use, resist or ignore – among other actions that might not be predictable – the concept of stigma.

My goal is, thus, not an uncommon one in sociology: to stipulate the "technical" understanding of a concept and then to inspect whether and how ordinary social actors understand and enact the phenomenon. However, my agenda differs from, for example, a study that attempts to expose how persons claiming otherwise are "really" racist or how factory workers "misunderstand" their sociologically-defined class position. I focus my analysis and criticism here on social science practitioners and the tendency among them to reference and reify a concept that can comprise, in perhaps more cases than not, an unwarranted assessment of the persons to whom it attaches. Instead of demeaning mundane knowledge (with concepts such as "symbolic racism" or "false consciousness," which malign the claims of persons studied), it is to the decidedly "non-everyday" knowledge that inheres in and constitutes social science that I wish to attend. To undertake this criticism I will be inspecting reasoning and theorizing, relevant to a study of stigma, in sociology (and related human sciences), as well as a site–in the interactional world of stroke survivors – where the concept "stigma" would seem to have a place in lived social experiences.

Before addressing either of these issues, I wish to clarify the theoretical source of this investigation, namely, the perspective of ethnomethodology. Ethnomethodology has contributed to sociological inquiry into sociology itself, as a belief system and a discursive arena that comprises practices of reasoning, argument, and a specialized vocabulary, among other components. These phenomena constitute not only the topics of sociology but also what "counts" as sociological investigation as against that of other social sciences as well as non-academic insights. Stigma fits into this perspective as a phenomenon that has evolved as an analytic and discursive resource in sociological, versus everyday, reasoning and description.

Ethnomethodology as a Sociology of Sociology

Since its invention, ethnomethodology (hereafter EM) has been brought to bear on the work practices of actors in many different settings, including the

scientific laboratory. This investigation extends that concern to the work of sociologists through the examination of their constitutive practices, as demonstrated in language use in sociological scholarship. This concern – a "sociology of sociology" – was one of the seminal topics in early EM, as demonstrated most explicitly in Cicourel's (1974) study of the reasoning practices that sociologists performed in a study of Argentine fertility and Garfinkel's (1967) reports on assumptions at work and the interactional construction involved in the production of sociological documents, including statistical analyses. More recently a paradigmatic project in this vein is that of Maynard and Schaeffer (1997, 2000) concerning the work of interactants in the accomplishment of survey interviews. All of these investigations considered that the same commonsense methods of reality construction that ordinary persons deploy – through conversations and other forms of interpersonal communication, through the sharing of a common argot, through the stipulation of what counts as defensible "knowledge" in specific contexts – are also the "methods" that sociologists engage in as they interact with one another, in verbal and nonverbal ways. Sociological knowledge, on this view, is not privileged insofar as it entails commonsense methods and competencies precisely as does any other form of knowledge, in and out of the academic realm.

With respect to theoretical works, the most important for this topic is Pollner's (1987) analysis into the background assumptions of an objective reality amenable for sociological inquiry as well as everyday life. Pollner clarifies EM's contribution to a sociology of sociology. EM, he writes,

> has striven, with various degrees of success, to make problematic the ways in which disciplines concerned with human behaviour conceptualize, research and account for human behaviour. The resultant inquiries have suggested that the production of 'objective' or scientific accounts of human behaviour are themselves permeated by rich, subtle practices and assumptions which are typically ignored or unrecognized – just as they are in everyday life (Pollner, 1987: ix).

Pollner deploys a number of examples in and out of sociology to support his argument, with emphasis on the ways in which actors in a traffic court invoke "reality" in the court proceedings and determine "what really happened" (Pollner, 1987: 23–25). This paper is an extension of his concerns but with a more specific focus, one warranted by the vast but largely unconsidered reliance on "stigma" in certain social scientific investigations.

I am referencing journal articles and scholarly monographs as sources of data for the first set of claims in this report. EM is adamantly empirical (Heritage, 1984). Some might thus argue that there are better sources for a study of the work of sociology, but in the culture of sociology it is these documents – books, and especially articles in academic journals – that furnish received knowledge and that provide and define the terms along which

knowledge is discussed. As iconoclastic as EM can be, it also partakes uncritically of this method of dispersing "knowledge." What sociologists "know" is received and disseminated via a written form, and so I am using that as a sort of archeological resource for reconstructing a field guide for the definition of one topic in sociology's received knowledge, a topic that constitutes an ethnomethodological resource for sociology's "members." That topic is stigma.

Stigma: A Field Guide for Sociologists

In undertaking a literature review for this piece, I came across dozens of titles published only in the last 6 years that at least contain the expression "stigma." In light of the size of this list of documents, I chose not to attempt their summary, but instead chose to focus on how social scientists recognize stigma. This is an important issue because, in nearly all cases, the term is invoked presumptively and as an independent or endogenous variable, or at the very least a "sensitizing concept" taken as given, the character or existence of which is not itself subject to scrutiny. Analysts similarly presume the deleterious impact of stigma. What follows is an inspection of the uses of "stigma" in the written discourse of social and behavioural sciences as examples of these tendencies.

Ascertaining "Stigma": A Quantitative Summary of Recent Literature

There is a wide range of conditions, characteristics and identities that social scientists have discerned as stigmatizing. Some unique examples of such stigmas are those seen as attaching to gambling (Preston et al., 1998), being a welfare recipient (Rogers-Dillon, 1995), being a victim in a battering relationship (Fiene, 1995), being infertile (Whiteford and Gonzalez, 1995), having an abortion (Mendoz et al., 1999), and even being perceived as Caucasian (Storrs, 1999).

However, each of these studies represent rarer strains among work that deploys the notion of stigma. There are, in the context of an almost bewildering diversity of studies, certain topics that researchers on stigma, or those who rely on the concept for interpretive or explanatory purposes, recurrently address. Table I presents the topics, and the number of studies on those topics, uncovered in a computerized search for pieces – journal articles as well as dissertations and abstracted association papers – for the period 1995 to 2001. Of about 180 titles, the topics that have gleaned at least two separate studies, and their incidences, are displayed in Table I.

Although it is conceivable that researchers have considered being male, being tall, or being rich – among a myriad of aspects of persons that might accrue negative social judgments – as "stigmatizing" in isolated studies, it is clear that the range of topics studied by more typical researchers, and the

Table I. Topics addressed as examples of "stigma" in scholarly journals, professional presentations and dissertations, 1995–2001

Condition or characteristic	Number of titles
AIDS or HIV infection	60
Homo- and bisexuality	14
Mental illness	9
Being overweight/eating disorders/body image	6
Prostitution	6
Tuberculosis	6
Epilepsy	4
Having a gay or lesbian parent	4
Imprisonment/other criminal-justice interventions	4
Incontinence	4
Race	4
Disability	3
Alcoholism	2
Brain injury	2
Other STDs	2

ways and venues in which "stigma" is imputed, is rather small and very clearly focussed. The evident plurality of these studies focus on HIV infection and AIDS, an area that I will presently address in more detail. I will first specify conditions, or qualities of conditions, that lend to treatment in social science as "stigmatizing."

How to Recognize "Stigma": Seven Signs

Goffman (1968: 14 – 15) argued that there are three "grossly different" types of stigma: stigma attaching to "physical deformities," or "abominations of the body"; stigma associated with "blemishes of character" and thus every sort of deviant conduct; and stigma accrued in "tribal" membership, as with being in a religious, ethnic or racial minority. Given this further specification, it is, perhaps ironically, clear that *any* condition, conduct or membership *can* be stigmatizing – insofar as it can be "discrediting," modifying Goffman's (1968:15) terminology – in some context. Given this, I ask how social scientists have managed to delimit stigma to the relatively small number of topics in Table I.

In attempting to answer this question, I teased out a number of qualitites that have emerged as tacit, "seen but unnoticed" criteria for ascertaining stigma, inspecting the titles and topics of the works uncovered for this review of the literature. These qualities are not characteristics of stigma; they do not *define* stigma as per Goffman's rendering of "tribal" stigma and so forth. Rather, these qualities have delimited the conditions that have emerged as viable examples

of stigma for professional sociology. This "field guide" may account for why certain statuses or conditions which indubitably fit Goffman's definitions– any of a virtually infinite range of pre-existing or situated identities – do not appear to be treated anywhere in recent or non-recent works as "stigmatising." I term these qualities "visibility," "severity," "contagiousness," "culpability," "difference," "incompetence," and "deviance." I have provided definitions and examples of each in Table II.

Depending, sometimes, on how generously one might define "stigmatizing" conditions, I would argue that *every one* evinces one or more of these qualities. However, these qualities provide necessary but not sufficient "signs" of stigma, because there is an unimaginably large number of conditions that also could be described as "different" and "deviant" and so forth that emerge nowhere in sociological literature as "stigmatizing." For example, as noted above, being wealthy can, in many contexts, accrue negative social judgements, and yet I have found no research that addresses the stigma of wealth. The social scientific "community," such as it is, produces a delimited number of topics construable as stigmas. The question is not whether wealth is stigmatizing; the question is why wealth is not considered in the same light as mental illness or AIDS.

To answer this question, I propose four additional qualifications for stigma that are virtually universal among the works just summarized, the last two of which speak to why wealth (among many examples) is not a topic for social scientists with respect to stigma. First, stigma is a quality of behaviours or conditions that must be knowable even if they are not known. This feature suggests that, and explains why, secreted conditions (such as undisclosed infection with HIV, "closeted" homosexuality, undisclosed mental illnesses, and the like) are often defined as stigmatizing. Second, stigma requires "management" on the part of persons stigmatized or institutions that process them. Analysts never construe stigmatized persons as having a passive relationship with stigma, even where those persons specifically deny (as examples below will illustrate) that they suffer from stigma. Third, stigma attaches to outcomes that are almost always negative. Where outcomes are positive (defined variously, of course) they entail overcoming stigma via this thing called "management" or through changes in societal definition of a condition as stigmatizing in the first place, sometimes as a felicitous outcome of what Schur [1980] famously called a "stigma contest." Finally, stigma and power are of inverse proportions, and so stigma victimizes those identified by sociologists as relatively powerless. Therefore, works on stigma focus not only on conditions that are "contagious" and so forth, but on conditions that are "contagious" and that women, African Americans, and various other relatively marginalised persons suffer.

There is no better example of the foregoing claims than the case of HIV-related stigma, which I will now discuss.

Table II. Qualities of conditions appropriate for study as "stigmatizing" for social scientists

Stigma-identifying quality	Definition	Examples of topics
Visibility	Being visually notable	Race, being overweight, disability
Severity	Being fatal or debilitating	AIDS, tuberculosis, brain injury
Contagiousness	Being, or being perceived as, contagious	AIDS, other STDs, tuberculosis
Culpability	Implying blame or delict	AIDS, other STDs, crime, alcoholism
Difference	Being rare in particular contexts	Race, homo- and bisexuality, having a gay or lesbian parent
Incompetence	Reflecting frailty, negating social and interactional competence	Mental illness, brain injury, disability, incontinence
Deviance	Attaching to an "alternative lifestyle"	Homo- and bisexuality, crime, prostitution

A Case in Point: "HIV-Related Stigma"

With respect to specific works that reflect these rules and priorities of social scientists, the plurality of recent works that relate to stigma concern the experiences of persons infected with HIV and/or diagnosed with AIDS. AIDS is an ideal example of a stigmatising condition based on the field guide above. AIDS can satisfy, depending on the social status of the person with AIDS, every one of its criteria: AIDS, if not HIV infection *per se*, can produce visually notable symptoms. AIDS is certainly "serious," and contagious, often affects persons whose social self-presentation comprises novel and "deviant" forms of fashion, lifestyle, and so forth; and infection with HIV, as a condition that is in most cases, in principle, preventable, can occasion blame and implications of culpability.

Perhaps because of its unique fittingness as a stigma-relevant topic, AIDS and HIV infection have earned their own form of stigma, one known as "HIV-related stigma" (cf. Herek, 1999; Leary and Schreindorfer, 1998). This version of stigma has been studied in its own terms as a decontextualized psychological topic, as in the works of Pryor et al. (1999), who attempted to uncover the information–processing aspects conducive to it, or Devine et al.'s (1999) study of the schematic representation of persons with HIV as "other." However, HIV-related stigma is also defined as a phenomenon that is exacerbated and informed by the various other "stigmatized" or marginal statuses that HIV-infected persons possess.

Researchers have specifically focussed on the additional burdens of gay men (Fullilove and Fullilove, 1999; Herek and Capitanio, 1999; Johnson and Barr, 1996; LePoire et al., 1997), African Americans (Boyle et al., 1999; Fullilove and Fullilove, 1999; Poindexter and Linsk, 1999), and especially women, who emerged as the overwhelmingly most common focus in HIV-related behavioural and sociological studies in the 1990s (Barnes et al., 1997; Bunting, 1996; Hackl et al., 1997; Ingram and Hutchinson, 1999; Lawless, Kippax and Crawford, 1996; Poindexter and Linsk, 1999). HIV-related stigma also victimizes the caregivers of persons with HIV, according to studies of their mothers (Boyle et al., 1999; Nehring et al., 2000), volunteers (Snyder et al., 1999), and health care workers (Green and Platt, 1999), whose fear of handling HIV-infected patients may further exacerbate the patients' own stigma.

Alonzo and Reynolds (1995) and Tewksbury and McGaughey (1997) address various techniques of the management of HIV-related stigma, by specifying, among other topics, persons' adapation to an "HIV identity" and their attempts to mitigate stigma's negative impacts on their selves. Caregivers, as sufferers of stigma, need management strategies as well, and Poindexter et al. (1999) suggest that some caregivers' relationship with "God," if not a judgmental church or its "gossiping" members, constitutes one approach. On balance, HIV-related research suggests in all cases that stigma is a potent force

in the lives of persons infected with HIV, but that this force is sometimes only threatened, or is in fact imposed by the person stigmatised himself or herself. For example, Green (1995) finds that persons with HIV anticipate greater amounts of social disapproval and "stigma" than can actually be shown to exist with opinion surveys. Poindexter and Linsk (1999) examine the experience of HIV-infected African-American women and find that their subjects do not generally claim to suffer this version of stigma owing to the hidden nature of their infection, which prompts the authors to suggest that the patients' stigma is "internalized."

AIDS and HIV infection are special conditions affecting communities of salient interest to many social scientists. It is, however, unclear how "HIV-related stigma" differs from any other variety of stigma. Studies seeking to measure the relative amount of stigma suffered by, or directed at, persons with HIV as against other illnesses have not been conclusive in demonstrating that HIV-related stigma is worse than that attached to things other than HIV or AIDS (cf. Crawford, 1996; Fife and Wright, 2000). More important for my purposes is not how vague or imprecise the concept might be, but that its existence is presumed even when respondents do not report it or its euphemisms. Hiding one's HIV status, for example, as Poindexter and Linsk's (1999) subjects do, is an activity that might have many motivations besides, or in addition to, "stigma," whatever "stigma" might be. An obvious example of a rationale for hiding one's HIV status would be to safeguard one's employment; others might include to spare loved ones from worry and even to facilitate sexual encounters. Regardless of these other possibilities, researchers take this strategy of hiding as evidence for and as caused by "HIV-related stigma." This phenomenon might even be purported to be "self-imposed," which tendency only complicates analysts's non-problematized use of the term. Describing HIV-impacted persons as having, as Poindexter and Linsk (1999) do, "internalized stigma," renders the concept indisputable and non-falsifiable. Persons who deny their victimization, according to this reasoning, have "internalized stigma" provided only that they report that they conceal their conditions and that the analyst, not the person with the condition, considers the condition *a priori* stigmatising. The concept is thus omnisciently applied to any condition that is hidden, regardless of the "victim's" emotional valence towards it or justification for secrecy about it.

Despite the possibility, as I have just expressed, of very serious opposition to its use on theoretical, philosophical or practical grounds, this phenomenon – self-induced or "internalized" stigma – is one of the most important working concepts in stigma-related investigations in and out of the HIV/AIDS arena. This is especially true in the study of other medical or psychological conditions that are not publically recognizable or visually remarkable. Hayward and Bright (1997) argue along these lines in a review of works on stigma and mental illness when they write that "self-stigmatization" can be as effectual

as that imposed by other persons. Also in the mental illness area, McCarthy et al. (1995), on finding that most inpatient psychiatric patients conceal their diagnoses and hospitalizations from other people, claim that this secrecy indicates the need to combat the "stigma" of mental illness and of psychiatric care.

This summary begs a couple of questions. How does an analyst distinguish stigma from certain emotional responses (shame, embarrassment, and the like)? In other words, for all of these "discrediting" characteristics, why rely on the idea of stigma in the first place, a phenomenon that locates harm and even malice as emanating from "the public"? Are there characterizations of persons and conditions that reference *emotions* that might better capture individuals' experiences? Is there any other alternative to terming these conditions or behaviours as stigmatizing, and if so, why are they virtually nowhere considered? In addition, is it ever possible for one to critically assess and even reject the notion that certain conditions are stigmatizing?

These questions are important for this report as the assertion of a "stigma" is rarely qualified and almost never problematized, even in works that deploy "stigma" in a contentious manner as an explanatory variable, as in Storrs' (1999) work which deftly and, some may argue, incorrectly suggests that stigma (and not, say, propinquity or cultural differences or just plain racism) is to be blamed for the dearth of mixed-race marriages in the US. The only contemporary works that I found that came close to problematizing stigma were those (e.g., Hayward and Bright, 1997; Fife and Wright, 2000) that only suggest that stigma is more severe in some instances than in others. No authors discuss, never mind dispute, the concept of stigma as an *a priori* phenomenon. However, in sociology, socio-demographic categories such as race, class, and gender can be contextualized, problematized, deconstructed, and even disputed ontologically. I ask why, then, sociologists have so rarely inspected stigma critically as a feature, like race, of persons and of social contexts that define persons.

I maintain, as stated earlier, that "stigma" is an element of sociologists' belief system: stigma is, for the practical purposes of doing sociology, an objective phenomenon the existence of which is presumed and which is deployed unreflectively for analytic and descriptive purposes. This presumed factual nature of stigma does not, however, require that it (again, like race, gender, etc.) cannot constitute a topic in its own right. I will further attempt this in the next section by examining one venue in which stigma might be empirically available as a topic of study.

"Stigma" as a Members' Resource: A Brief Empirical Demonstration from Findings from Investigations of Stroke Survivors

I choose to ascertain whether real social actors orient to stigma, and as such whether conditions defined in sociological studies as "stigma" can be

reasonably defined as such based on evidence from lived experience. These questions allude to a radical critique of the concept, not a critique that contends anything about the *existence* of stigma, but a critique that seeks to recast it as a member's phenomenon (including "members" who are professional social scientists deploying the concept as a resource for their work) and to ask where, how, and *whether* "stigma" is used in concrete social interaction before implementing it as an analytic anchor.

This "critique" relies on insights and methodological and theoretical imperatives from conversation analysis (CA), an empirically focussed variant of EM. What CA offers for this investigation is a criterion of evidence for casting "stigma" as an element of real, and not stereotyped, social experience via the inspection of talk and related social interaction (preferably for my purposes involving a person or persons who are seen, or who can be seen, as experiencing stigma). CA recommends concrete methodological steps for that investigation, via recording, close transcription, and recurrent viewing of data that are not reduced or idealized beyond their literal transcription.

Data and Method

For this part of the investigation I inspected transcripts of about 40 h. of interviews, each comprising a stroke survivor, his or her spouse, and an interviewer. Interviews were open-ended and lasted, on average, 90 min. The focus of the data collection was to gauge patients' linguistic recovery by observing their language use in non-clinical, natural settings (the patients' homes) in casual talk with interactants with whom the patient was familiar. A great deal of the interviews comprised talk about the stroke itself and its psychological and social effects, and so I surmised that some attention to the "stigmatising" aspect of stroke might be present and instructive for this report.

Finding 1: Seeking "Stigma"

The first question that I confronted was how to determine if talk addressed "stigma." For this preliminary attempt I decided to conduct a word search for the expression "stigma" and any of some of several synonyms that contained its sense, such as "shame" and "blemish." This approach might seem unfair to the evocative expression "stigma," but as a first step I sought to determine whether there was any confluence between analysts' and participants' reliance on the term. What I mean by this is that the expression "stigma," although its definition might be implicit, is *ex*plicitly iterated in social scientific literature. Indeed, its iteration was what permitted the literature review and critique in this investigation. I thus sought first to see whether these interactants actually mentioned the word itself, as social scientists do.

Perhaps unsurprisingly, there were no uses of the term at all (or for that matter, "stigmatising" or "stigmatised"), and the only two references to "shame"

concerned non-stroke-related topics, as when one stroke survivor remarked, "I'm ashamed to say I don't read the Bible as much as I should." Based on my adherence to CA's empiricism, I would use this finding to resist description of stroke as "stigmatizing," for these subjects at least, and would additionally question analysts' use of the term in general unless they consider whether their own subjects appear to orient to it.

One might of course counter that the management of stigma attaches not to the organization of the expression, but rather to how stigmatized persons manage the negative social responses to them. In other words, one may defend sociologists' use of the expression by noting that, whether ordinary people use the word "stigma" or not, persons with stigmatising conditions do suffer negative consequences related to those conditions in social settings. To consider this claim, I turned to a study using data that addressed interactants' responses to stroke survivors' behaviours specifically.

Finding 2: The Interpersonal "Management" of "Stigma"

In an earlier product of this stroke-related research project, the investigators considered how stroke survivors and their interlocutors managed the survivors' crying (Manzo et al., 1998). Persons who have had strokes, including those in this study, cry with notable frequency, and inspection of crying episodes suggested that this tendency is often troubling for the crier and his or her interactants. What Manzo et al. (1998) found, however, was that in the sequelae of crying, the criers, in concert with others party to the crying, worked in every instance to recast the crying as normal, as warranted, as generally within the boundaries of socially accepted emotional displays no matter how abnormal the crying might have appeared to be clinically.

Unaccountable, or so-called "pathological," crying might be taken *a priori*, along the lines of traditional attention to this topic, as a "stigmatising" aspect of post-stroke behaviour. But the stroke survivors and their spouses rendered it in every case as "normal," a fact that would remain undiscovered if crying had been initially and omnisciently defined as stigmatizing and subject to management as such. Yet another earlier investigation along these lines (Manzo, et al., 1995) found that stroke survivors' linguistic recovery could be impeded by their spouses' refusal to allow the patients to tell stories unassisted. This earlier finding bolsters a more general argument, namely, that persons who have experienced strokes might enjoy faster recovery, and a better quality of life, if they could evade social expectations concerning what their levels of competence are. Part of this, to return to the more general topic in this report, is to allow speakers to express whether and to what degree they find their conditions to be stigmatizing. Based on the interviews scrutinized here, it does not appear that the stroke survivors suffer from stigma at all. The very suggestion that stroke (and presumably head injuries and other neurological

impairments) are "stigmatising" should attend to the survivors' experiences with them before such assertions are made.

The point I wish to make with respect to stigma is that summarizing such varied, adaptable and micro-socially organized behaviour with the gloss of "stigma" fails to capture what actors are accomplishing in any context, not only with respect to survivors of stroke. Stigma can be not only an inappropriate term for the phenomenon under study but can also impede researchers from noticing the extent to which persons might undo or manage or make irrelevant the victim-casting status that the expression "stigma" implies. The subjects in this study appear to evade stigma entirely, in concert with their co-conversationalists.

Discussion

My goal has not been to assess conditions as "really" stigma or not, but to consider how the concept has been organized by social actors. This concern is two-fold: first, I have considered how the expression "stigma" has constituted a feature of the discourse and knowledge in/of sociology, and what stigma, as a gloss of a large range of purported conditions and behaviours, looks like and "means" in sociological writings. I have secondly considered how "stigma" might stand as a members' resource by inspecting linguistic data that attach to a condition – brain injury (cf. Dann, 1997; Nochi, 1998) – that can be, and has been, described by social scientists as "stigmatising." Perhaps unsurprising is the finding that the sociological summary of a "stigma" is an overused and underdefined concept that does not grasp sociality.

This central finding does not in itself constitute a criticism of sociology tout court, because other concepts, concepts such as "race," "gender," "class," "deviance," and virtually countless others, constitute similar sociological glosses; it might indeed be asserted that sociology (including its ethnomethodology subfield) could not exist without these "mundane idealizations," (Pollner, 1987) which are tacit, ideal–typical summaries of richly varied and complex phenomena and processes. It can be argued that "stigma" is simply one of a huge range of mundane idealizations found in the human sciences.

It is difficult to impugn the use of "stigma," as a working concept, in sociology without expressing a critique of the entire discipline. I will argue that what I find especially "bad," or disturbing, about this thing called "stigma" is that the concept has engendered policy and policy responses – that is, *institutional* management practices–to "treat" it with little attention as to its grounded character (in other words, with little attention to whether and how real persons actually orient to or iterate the expression) or with meagre or no consideration as to the fittingness of the term "stigma" in the first place. In many, perhaps most cases, the reliance of analysts on stigma as a kind of editorial gloss can and should be questioned, if not eliminated, especially when

it ignores Goffman's early stipulation that stigma attaches not only to persons but to specific social contexts. Stigma, to the extent it might be really extant in the first place, should thus not only be what sociologists and other behavioural scientists *choose*, often capriciously, to call stigma. Stigma should, I argue, be "real" for participants as well; it should constitute part of their own ethnomethods, and not only those of sociologists, before stigma can be analyzed objectively, maligned, prevented or cured.

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